



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA HOSPITAL OF DALLAS
4301 VISTA ROAD
PASADENA TEXAS 77504

Carrier's Austin Representative Box

19

Respondent Name

ZURICH AMERICAN INSURANCE CO

MFDR Date Received

MAY 24, 2005

MFDR Tracking Number

M4-05-8432-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated July 18, 2006: "The Carrier has not made a legal denial of reimbursement under the applicable rules and statutes...Vista was not provided with a sufficient explanation or the proper denial reasons to justify the denial of reimbursement of the disputed charges upon reconsideration." "Carrier may reimburse at a 'per diem' rate for the hospital services if the total audited charges for the entire admission are below \$40,000, after the Carrier audits the bill pursuant to the applicable rules. However, if the total audited charges for the entire admission are above \$40,000, the Carrier shall reimburse using the Stop-Loss Methodology in accordance with the plain language of the rule contained in § 134.401(c)(6)(A)(iii). This rule does not require a hospital to prove that services provided during the admission were unusually extensive or unusually costly to trigger the application of the Stop Loss Methodology. It is presumed that the services provided were unusually extensive or unusually costly when the \$40,000 stop-loss threshold is reached."

Requestor's Supplemental Position Summary Dated February 15, 2013: "According to the Third Court of Appeals' opinion, a provider is entitled to reimbursement under the 'Stop-Loss' exception in the Acute Care Inpatient Hospital Fee Guideline if the audited billed charges exceed \$40,000 and if the surgery(ies) performed on the claimant were unusually extensive and unusually costly...When these elements are proven, then the provider is entitled to be paid 75% of its billed charges. The medical records on file with MDR and the additional records attached hereto, show this admission to be a complex spine surgery...This complex spine surgery is unusually extensive for at least three reasons.....the medical and billing records on file with MDR and additional records attached hereto also show that this admission was unusually costly because it was necessary to purchase expensive implants for use in the surgery and a cell saver and neuromonitoring was required in this procedure."

Amount in Dispute: \$38,610.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated June 17, 2005: "The Requestor asserts it is entitled to reimbursement in the amount of \$90,643.53, which is 75% of the total charges. Requestor has not shown entitlement to this alternative, exceptional method of calculating reimbursement...Carrier requests an **Order of Reimbursement** for any payment previously made over the amount calculated under the methods described in the above referenced SOAH decisions..."

Respondent's Supplemental Position Summary Dated February 15, 2013: "Respondent submits this Respondent's Post-Appeal Supplemental Response as a response to and incorporation of the Third Court of Appeals Mandate in Cause No. 03-07-00682-CV...Based upon Respondent's initial and all supplemental responses, and in accordance with the Division's obligation to adjudicate the payment, in accordance with the Labor Code and Division rules, Requestor has failed to sustain its burden of proving entitlement to the stop-loss exception. The Division must conclude that payment should be awarded in accordance with the general *per diem* payment in accordance with 28 Texas Administrative Code §134.401 (repealed)..."

Responses Submitted by: Flahive, Ogden & Latson, 505 West 12th Street, Austin, Texas 78701

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
June 30, 2004 through July 2, 2004	Inpatient Hospital Services	\$38,610.56	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
3. 28 Texas Administrative Code §134.1, 27 *Texas Register* 4047, effective May 16, 2002, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.
4. 28 Texas Administrative Code §133.304, 17 *Texas Register* 1105, effective February 20, 1992, amended effective July 15, 2000 sets out the procedures for medical payments and denials.
5. Former 28 Texas Administrative Code §133.304(p), 17 *Texas Register* 1105, effective February 20, 1992, provided, in pertinent part, that "An insurance carrier may request medical dispute resolution in accordance with §133.305 if... the insurance carrier has requested a refund under this section."

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- F-Fee Guideline MAR reduction.
- N-Not documented.
- Please see Excel spreadsheet re: undocumented/questionable charges deducted from total pending documentation & implant spreadsheet. Pd implants at cost plus 10% and remainder at fair and reasonable for stop loss.
- A46-Additional allowance per MCSC M.D./R.N. Review.
- S-Supplemental Payment.

Issues

1. Did the audited charges exceed \$40,000.00?
2. Did the admission in dispute involve unusually extensive services?
3. Did the admission in dispute involve unusually costly services?
4. Is the requestor entitled to additional reimbursement?
5. Is the respondent entitled to an order or reimbursement or refund?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 *Texas Register* 6264. The Third Court of Appeals' November 13, 2008

opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 South Western Reporter Third 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that “to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services.” Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The division received supplemental information as noted in the position summaries above. The supplemental information was shared among the parties as appropriate. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals’ November 13, 2008 opinion, the division will address whether the total audited charges **in this case** exceed \$40,000; whether the admission and disputed services **in this case** are unusually extensive; and whether the admission and disputed services **in this case** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that “Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection...” 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. The requestor in its position statement asserts that “The Carrier has not made a legal denial of reimbursement under the applicable rules and statutes...Vista was not provided with a sufficient explanation or the proper denial reasons to justify the denial of reimbursement of the disputed charges upon reconsideration. 28 Texas Administrative Code §133.304(c), 17 Texas Register 1105, effective February 20, 1992, applicable to dates of service in dispute, states, in pertinent part, that “At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s). A generic statement that simply states a conclusion such as ‘not sufficiently documented’ or other similar phrases with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section.” Review of the submitted documentation finds that the explanation of benefits were issued using the division-approved form TWCC 62 and noted payment exception codes “F, N, S, and A46.”

These payment exception codes and descriptions support an explanation for the reduction of reimbursement based on former 28 Texas Administrative Code §134.401. These reasons support a reduction of the reimbursement amount from the requested stop-loss exception payment reimbursement methodology to the standard per diem methodology amount and provided sufficient explanation to allow the provider to understand the reason(s) for the insurance carrier's action(s). The division therefore concludes that the insurance carrier has substantially met the requirements of 28 Texas Administrative Code §133.304(c).

2. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states “...to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed \$40,000, the minimum stop-loss threshold.” Furthermore, (A) (v) of that same section states “...Audited charges are those charges which remain after a bill review by the insurance carrier has been performed...” Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal \$120,858.03. The Division concludes that the total audited charges exceed \$40,000.
3. As noted above, the Third Court of Appeals’ November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 South Western Reporter Third 538, 550 (Texas Appeals – Austin 2008, petition denied) rendered judgment to the contrary. In its supplemental position statement, the requestor considered the Courts’ final judgment and opined on both rule requirements. In regards to whether the services were unusually extensive, the Third Court of Appeals’ November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually extensive services. Rule §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that “This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission.” The requestor’s supplemental position statement asserts that:

“The medical records on file with MDR and the additional records attached hereto, show this admission to be a complex spine surgery, specifically a five hour surgery with a 360 degree anterior lumbar interbody fusion along with posterior lumbar fusion at L5-S1 with iliac crest bone marrow grafting and instrumentation. This complex spine surgery is unusually extensive for at least three reasons: first, this surgery as noted above required extensive spinal instrumentation; second, and arterial line had to be

placed to monitor blood pressure changes in real time instead of a conventional blood pressure monitor; and third, the patient post-operatively required aggressive pulmonary toilet and required extra oxygen to keep O₂ saturations above 90%.”

The requestor did not submit documentation to support the reasons asserted that this spinal surgery was unusually extensive. The reasons stated are therefore not demonstrated. Additionally, the requestor's position that all spinal surgeries are unusually extensive does not satisfy §134.401(c)(2)(C) which requires application of the stop-loss exception on a case-by-case basis. The Third Court of Appeals' November 13, 2008 opinion affirmed this, stating “The rule further states that independent reimbursement under the Stop-Loss Exception will be ‘allowed on a case-by-case basis.’ *Id.* §134.401(c)(2)(C). This language suggests that the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases.” The requestor's position that all spine surgeries are unusually extensive fails to meet the requirements of §134.401(c)(2)(C) because the particulars of the services in dispute are not discussed, nor does the requestor demonstrate how the services in dispute were unusually extensive in relation to similar spinal surgery services or admissions. For the reasons stated, the division finds that the requestor failed to demonstrate that the services in dispute were unusually extensive.

4. In regards to whether the services were unusually costly, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services. 28 Texas Administrative Code §134.401(c)(6) states that “Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker.” The requestor's supplemental position statement asserts that:

“The medical and billing records on file with MDR and additional records attached hereto, also show that this admission was unusually costly because it was necessary to purchase expensive implants for use in the surgery and a cell saver and neuromonitoring was required in this procedure. Therefore, reimbursement should be in an amount which is 75% of billed charges which is \$90,643.52”

The requestor asserts that because the **billed charges** exceed the stop-loss threshold, the admission in this case is unusually costly. The Division notes that audited charges are addressed as a separate and distinct factor described in 28 Texas Administrative Code §134.401(c)(6)(A)(i). Billed charges for services do not represent the cost of providing those services, and no such relation has been established in the instant case. The requestor fails to demonstrate that the **costs** associated with the services in dispute are unusual when compared to similar spinal surgery services or admissions. For that reason, the division rejects the requestor's position that the admission is unusually costly based on the mere fact that the billed or audited charges “substantially” exceed \$40,000. The requestor additionally asserts that certain resources that are used for the types of surgeries associated with the admission in dispute (i.e. specialized equipment and specially-trained, extra nursing staff) added substantially to the cost of the admission. The requestor does not list or quantify the costs associated with these resources in relation to the disputed services, nor does the requestor provide documentation to support a reasonable comparison between the resources required for both types of surgeries. Therefore, the requestor fails to demonstrate that the resources used in this particular admission are unusually costly when compared to resources used in other types of surgeries.

5. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements*. The Division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.
 - Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that “The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission...” Review of the submitted documentation finds that the length of stay for this admission was two ICU/CCU; therefore, the standard per diem amounts of \$1,560.00 multiplied times two days results in an allowable amount of \$3,120.00.
 - 28 Texas Administrative Code §134.401(c)(4)(A), states “When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274).”
 - A review of the submitted medical bill indicates that the requestor billed revenue code 278 for Implants at \$52,732.00.

- The Division finds the total allowable for the implants billed under revenue code 278 is:

Description of Implant per Itemized Statement	Quantity	Cost Invoice	Cost + 10%
Accell Connexus 10cc	1	\$1,100.00	\$1,210.00
BAK Vista 17 x 20mm	1	\$3,995.00	\$4,395.50
Screw Mutli Blackstone	4	\$1,285.00/each	\$5,654.00
Screw Set Blackstone	4	\$160.00/each	\$704.00
Rod TI Blackstone	2	\$255.00/each	\$561.00
Connector Cross 40mm	1	\$1,495.00	\$1,644.50
TOTAL	13		\$14,168.00

6. In its response to the request for medical fee dispute resolution, the insurance carrier and respondent in this dispute requested "Carrier requests an Order of Reimbursement for any payment previously made over the amount calculated under the methods described in the above referenced SOAH decisions." Former 28 Texas Administrative Code §133.304(p), 17 Texas Register 1105, effective February 20, 1992, provided, in pertinent part, that "An insurance carrier may request medical dispute resolution in accordance with §133.305 if... the insurance carrier has requested a refund under this section, and the health care provider: (1) failed to make payment by the 60th day after the date the insurance carrier sent the request for refund..." Former 28 Texas Administrative Code §133.305(a)(2)(C), 27 Texas Register 12282, effective January 1, 2003, provided that "a carrier dispute of a health care provider reduction or denial of the carrier request for refund of payment for health care previously paid by the carrier (refund request dispute)" can be a medical fee dispute. Former 28 Texas Administrative Code §133.307(b)(3), 27 Texas Register 12282, effective January 1, 2003, specified that "The carrier... in a dispute involving a carrier's refund request" may be a requestor in a medical fee dispute. Section 133.307(e) required that "...carrier requests for medical dispute resolution shall be made in the form, format, and manner prescribed by the commission." Section 133.307(e)(2)(B) required that the request shall include "a copy of each... response to the refund request relevant to the fee dispute..." The division finds that the insurance carrier's position statement in response to the health care provider's request for medical fee dispute resolution does not constitute a request for refund request dispute resolution in the form and manner required by former applicable version of 28 Texas Administrative Code §133.307. Furthermore, no documentation was found to support that the insurance carrier ever presented a refund request to the health care provider to support its burden of proof for a specific refund amount in accordance with §133.304(p). The division concludes that the insurance carrier has not met the requirements of §133.304(p) or §133.307(e). For these reasons, the respondent's request for an order of reimbursement is not proper, and is not supported. An order of reimbursement for the respondent is therefore not recommended.

The division concludes that the total allowable for this admission is \$17,288.00. The respondent issued payment in the amount of \$52,032.96. Based upon the documentation submitted no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed \$40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount*, and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

_____	_____	2/26/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.